Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Earl F. Hendrikz, DC

Respondent Name
Insurance Company of the State of Pennsylvania

MFDR Tracking Number
M4-14-2447-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was for a Division ordered Designated Doctor Re-Exam. We billed a total of $2,275.00 for this claim and were paid only $627.96. The explanation given on the correspondence justifying the denial states: *THIS PROCEDURE WAS REDUCED TO 25 PERCENT OF THE PRIMARY PROCEDURE PER GUIDELINES;* however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: $472.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 18, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2013	Designated Doctor Exam to Determine if Disability is Related to Compensable Injury and Return To Work Status	$472.04	$472.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 134.204 (i) defines the modifiers for billing questions that a Designated Doctor may address and reimbursement percentage of questions other than Maximum Medical Improvement and Impairment Rating.
3. 134.204 (k) provides the reimbursement amount for Return to Work and Evaluation of Medical Care questions.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (W1) Workers Compensation State Fee Schedule Adjustment.
   - 1 – No Reduction Available. (VRNA)
   - 2 – (16) Claim/service lacks information which is needed for adjudication.
   - 2 – The amount paid reflects a fee schedule reduction. (P300)
   - 3 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 3 – The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 4 – THIS PROCEDURE WAS REDUCED TO 25 PERCENT OF THE PRIMARY PROCEDURE PER GUIDELINES. (M479)

Issues

1. What is the correct reimbursement amount for the Designated Doctor's evaluation of whether disability is related to the compensable injury?
2. What is the correct reimbursement amount for the Designated Doctor's evaluation of the injured employee's ability to return to work?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (i), "Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: … (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W6;' (D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W7;' (E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W8'; …(2) **When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section**; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section" [emphasis added], and 28 Texas Administrative Code §134.204 (k) states, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." **In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section** and shall include Division-required reports" [emphasis added]. Based on the above referenced rules, the correct reimbursement amount for the Designated Doctor's evaluation of whether disability is related to the compensable injury is $500.00.
2. Per 28 Texas Administrative Code §134.204 (i)(2)(B) referenced above, the correct reimbursement amount for the Designated Doctor's evaluation of the injured employee's ability to return to work is $250.00.
3. After reviewing the submitted documentation, the Division finds that the insurance carrier paid $125.00 for the Designated Doctor's evaluation of whether disability is related to the compensable injury and $125.00 for the evaluation of the injured employee's ability to return to work.

   An additional $375.00 is recommended for the Designated Doctor's evaluation of whether disability is related to the compensable injury. Further, an additional $125.00 is recommended for the Designated Doctor's evaluation of the injured employee's ability to return to work. Total recommended MAR for the unpaid balance is $500.00.

   The requestor is seeking additional reimbursement of $472.04. Therefore, the recommended additional reimbursement is $472.04.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $472.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $472.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 11, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.